



**REPUBLIC OF ZAMBIA**

**REPORT**

**OF THE**

***COMMITTEE ON HEALTH, COMMUNITY  
DEVELOPMENT AND SOCIAL WELFARE***

**FOR THE**

**FIFTH SESSION OF THE NINTH NATIONAL  
ASSEMBLY APPOINTED ON 19<sup>TH</sup> JANUARY 2006**

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## TABLE OF CONTENTS

<i>ITEM</i>	<i>PAGE</i>
1. Composition of the Committee	1
2. Functions of the Committee	1
3. Meetings of the Committee	1
4. Programme of Work	1
5. Procedure adopted by the Committee	2

### PART I

#### CONSIDERATION OF TOPICAL ISSUES

6. Study on Provision of Quality Visual/Eye Health Related Services in Zambia	2
<i>Committee's Observations and Recommendations</i>	8

### PART II

7. Tours	
(i) Munali Boys High School	9
Committee's Observations and Recommendations	10
(ii) University Teaching Hospital Eye Clinic	11
Committee' Observations and Recommendations	11
(iii) Seventh Day Adventist Lusaka Eye Hospital	11

Committee's Observations and Recommendations	11
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### PART III

8.	Consideration of outstanding issues in the Action-Taken Report on the Committee's Report for 2005	12
9.	<b>Conclusion</b>	23

**REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL WELFARE FOR THE FIFTH SESSION OF THE NINTH NATIONAL ASSEMBLY APPOINTED ON 19<sup>TH</sup> JANUARY, 2006**

Consisting of:

Mr Y D Mukanga, MP (Chairperson); Mr L Chikoti, MP; Mr P G Phiri, MP; Mr D Kayaba, MP; Mr N Sambwa, MP; Mr R M Kapita, MP; Dr K Kalumba, MP; and Ms Q V Kakoma, MP.

The Honourable Mr Speaker  
National Assembly  
Parliament Buildings  
**LUSAKA**

Sir,

Your Committee have the honour to present their Report for the year 2006

**Functions of the Committee**

2. The functions of your Committee, as set out in the National Assembly Standing Orders, are as follows:
  - a) study, report and make recommendations to the Government through the House on the mandate, management and operations of the Ministries of Health and Community Development and Social Services, departments and agencies under their portfolios;
  - b) carry out detailed investigations or scrutiny of certain activities being undertaken by the Ministries of Health and Community Development and Social Services, departments and agencies under their portfolios and make appropriate recommendations to the House for appropriate consideration by the Government;
  - c) make, if considered necessary, recommendations to Government on the need to review certain policies and certain existing legislation;
  - d) examine in detail the annual reports of the Ministries of Health and Community Development and Social Services and departments and agencies under their portfolios and determine whether the affairs of the said bodies are being managed according to relevant Acts of Parliament, established regulations, rules and general orders;
  - e) consider any Bills that may be referred to them by the House.

**Meetings of the Committee**

3. During the year under review, your Committee held nine meetings.

**Programme of Work**

4. At their Second Meeting held on 31<sup>st</sup> January, 2006 your Committee adopted the following programme of work:
  - a) consideration of the Action Taken Report on the Committee's Report for 2005;
  - b) study the provision of quality visual/eye health related services in Zambia; and

- c) tours to selected health institutions providing eye health services.

**Procedure adopted by the Committee**

5. Your Committee requested detailed memoranda on the topic under consideration from the Ministry of Health and other stakeholders concerned. Thereafter, the Ministry of Health and other stakeholders were invited to appear before your Committee to give verbal submissions and clarifications on issues arising from their submissions.

**PART I**

**TOPICAL ISSUES**

**Provision of quality visual/eye health related services in Zambia**

6. In 1985 Zambia was reported to have a high incidence and prevalence of blindness, with Luapula valley contributing significantly to the total number of blind persons. A task force was then formed by Government to spearhead Government interventions in the quest to prevent avoidable blindness and provide eye health care.

Due to the advent of the problem of the HIV/AIDS pandemic and the magnitude of the problem, issues such as eye health care may be over shadowed yet the country needs comprehensive and quality eye health care in order to prevent avoidable blindness and other preventable and curable eye complications.

In view of the foregoing, your Committee decided to study in detail the provision of eye health related services in Zambia vis-à-vis Government policy on eye health and care.

**SUBMISSION BY THE PERMANENT SECRETARY, MINISTRY OF HEALTH  
Government Policy on the provision of quality eye health services**

Your Committee were informed that there was no policy on eye health, but the Ministry of Health was yet to develop one. However, the Ministry of Health has developed a Five-Year National Eye Health Strategic Plan. The Eye Health Strategic Plan would be implemented within the framework of Health Vision Goals and Policies and the National Strategic Plan 2006-2011.

The National Committee on Prevention of Blindness had been established and is functional. Membership on the committee comprised various stakeholders. A number of eye specialists have been employed and are serving in Government hospitals. However, many more are required. There are 50 Ophthalmic Clinical Officers who are mainly in Government service. Plans are under way to start a training school for Ophthalmic Clinical Officers at Chainama, and it is envisaged that it will start operating in July 2006. The school would train between 12 and 15 Ophthalmic Clinical Officers every 18 months.

The aim is to provide manpower to all provincial and district hospitals and major rural health centres.

The role of the National Committee for Prevention of Blindness is to advise the Ministry of Health on eye health issues and monitor the implementation of the eye health related programmes under the Ministry of Health.

**National overview of the Blindness Situation, its Prevention and Eye Care Service Delivery**

Your Committee learnt that it is estimated that Zambia has a prevalence of blindness of 1% of the total population that is, there are 103,000 blind persons. Eighty percent of cases of blindness are preventable. There has however, not been a complete survey done on the distribution patterns of blindness in the country

but some areas had been zoned as having a high prevalence of specific eye conditions, which contribute to blindness. For instance, Trachoma is common in Gwembe while Vitamin A deficiency is common in Luapula Province.

The major causes of blindness in Zambia had been identified as follows:

- Cataract
  - Glaucoma
  - Trachoma
  - Cornea opacities due to:
    - Measles, etc
    - Vitamin A Deficiency
    - Traditional eye practices
    - Ophthalmic neonatorum
    - Ocular injuries
    - Trachoma
- (i) Cataract is a major cause of blindness in Zambia accounting for at least 50 to 60% of blindness. It is estimated that at least 1 person per 1000 become blind every year. The Cataract Surgical Rate (CSR) is currently 500, but that is far less than Europe's CSR of 2, 500. It was estimated that 50-60% of blindness is due to cataract and is treatable.
- (ii) Trachoma, an infection of the eye is the second commonest cause of blindness in Zambia. However, blindness caused by trachoma can be prevented through improved community sanitation, water supply and personal hygiene. Trachoma is a facial disease in Zambia and some trachoma districts have been identified, namely; Kalabo and Senanga in Western province, Gwembe in Southern Province, Chama in Eastern province and Mufulira in Copperbelt Province. However, there is need to do surveys to identify the disease in other parts of Zambia.
- (iii) Glaucoma is another cause of treatable blindness. It is responsible for 10-15% of the blind population in Zambia.
- (iv) Corneal Opacities as a result of infections, injuries and malnutrition contributes to the high prevalence of childhood blindness estimated at 0.9 per 1000 children. An estimated 24,000 children need spectacles for significant refractive errors.
- (v) In addition to the above-mentioned causes of blindness, there are some systematic diseases such as Diabetic mellitus, which can lead to complications causing blindness for example cataract and Diabetic Retinopathy.
- (vi) Onchocerciasis has not been identified in Zambia despite the fact that the disease is common in some neighbouring countries like Malawi, Congo DR and Tanzania. It might be necessary to carry out research to establish the presence of the disease.

### **Service Delivery**

At present, eye care services are provided mainly at provincial centres and referral hospitals. The major hospitals offering tertiary eye care services are the University Teaching Hospital, Kitwe Central Hospital and Lusaka Eye Hospital. Outreach programmes are, however, inadequate. The few ophthalmologists in the country based in Lusaka and the Copperbelt provide some outreach services to various parts of the country such as Luapula (Mansa), Northern (Kasama), North-Western (Solwezi), Central (Kabwe) and Southern (Macha, Mazabuka, Monze, Zimba and Livingstone) Provinces. The ophthalmologist in Eastern Province based at St Francis General Hospital in Katete covers other parts of Eastern Province (Chipata and Lundazi).

The mission hospitals like Mwami Adventist Hospital, Chikankata Salvation Army Hospital and Mukinge Baptist Hospital also have eye sections. Non-governmental organisations such as Sight Savers International (SSI), Christophel Blindern Mission (CBM) and Operation Eyesight Universal (OEU) provide financial and material support to eye care programmes in Lusaka, Copperbelt and North-Western Provinces (SSI and CBM) Lusaka (OEU). These complement Government efforts.

There are a few hospitals that have an ophthalmologist but are under utilised and these include Ndola Central and Livingstone hospitals. The reasons for under utilisation include lack of ophthalmic surgical equipment.

Although school health services are inadequate because of human resources, school teachers are currently being taught to detect low vision in children.

The major challenges in prevention of blindness currently are:

1. poorly established National Blindness Prevention Programme;
2. grossly inadequate cover of specialised ophthalmic human resource at central and provincial levels to form a catalyst for the National Prevention of Blindness Programme;
3. grossly inadequate physical facilities for both service and training at national and provincial levels associated with poor equipment and transport;
4. tertiary centres not functioning as referral centres, and centres for development of Prevention of Blindness Programme; and
5. lack of prevention of blindness activities.

**Table 1: Current situation and expected situation by years (2006 – 2020)**

Description	Current Situation (Year 2006)	Year 2015	Preferred Future by 2020
Prevalence and main causes of blindness	The prevalence of blindness is estimated to be 1.0% (103,000). Of this figure, cataract causes 50%; Glaucoma and corneal scars are the other main causes. The prevalence of childhood blindness is estimated to be 0.9 per 1,000 children (4320). Corneal scars and cataract are the main causes of childhood blindness. An estimated 24,000 children need spectacles for significant refractive errors. No specialised low vision services for children exist.	0.8%	Prevalence of blindness will be 0.5%
Ophthalmologists	15 (4 in Government practice in Lusaka (UTH), 4 in private practice in Lusaka; 1 in Military practice in Lusaka (Maina Soko) 1 in private practice in Ndola, 2 in Government practice in Kitwe (Kitwe Central Hospital, 1 in private practice (Kitwe); 1 in Mission practice in Lusaka (Lusaka Eye Hospital); 1 in Government service (Katete); 1 in Government service (Ndola Central Hospital)	20 (to train 2 per year)	30 (to train 2 per year)
Ophthalmic Medical Licentiate (Cataract Surgeon)	2 (1 at a Military Hospital in Lusaka and 1 at the Mission Hospital – Mwami)	15	40
Ophthalmic RN	5	20	100
Eyes Nurses	20	60	200
Optometrists	2	05	20
Ophthalmic EN	2	10	90



Ophthalmic Instrument Technician	2 (at Mwami Hospital)	05	10
Cataracts Surgical Rate:	The CRS is unknown but is estimated to be about 500 per million population per year. The recommended minimum for Africa is 2000	1500	2000
Optical workshops:	1. Mwami Hospital 2. St Francis Hospital, 3. Mukinge Hospital Kasempa 4. Private: Lusaka, Ndola, Kitwe	10	15
Local Production of Eye Drops(LPED)	Mwami Hospital Eye Department: ZFDS Macha Mission Hospital has an LPED unit that produces a range of eye drops for use in hospitals and clinics in Zambia.	10	10

Your Committee heard that with the political will and support from cooperating partners, the time to act had come. Cooperating partners (SSI, CBM and OEU) were very keen to support the Zambia Eye Care Programme. Further, the district plans for eye health that district centres are currently in the process of developing are the initial steps to further establish eye services in Zambia.

**The operation of the referral system, specifically in relation to provision of quality eye -health care services and the role of the private eye health care service providers**

Your Committee were informed that, currently, patients were referred from one Government institution to the next higher level of Government facility. Normally, the patient would report at the nearest health centre in his/her locality. If the only service provider available are the private practitioner, patients go there at their own cost. A system has not yet been developed of making full use of the private practitioner. There is need to develop a system where Government could use the services of private practitioners in Government institutions or in their own private clinics/hospitals and Government would pay for such referrals. This is in view of the fact that out of the 15 Ophthalmologists in the country 50-60% are in private practice.

**Way forward for provision of quality eye health services**

1. Human resource development: There is need to train more ophthalmologists, Cataract Surgeons, Ophthalmic Clinical Officers and Ophthalmic Nurses. Establishing a training school for Ophthalmic Clinical Officers and Ophthalmic Nurses would be the starting point. Cataract surgeons could be trained through existing institutions. The Plan is in place to start training ophthalmologists outside the country through a Government programme.
2. Infrastructure development: Establishing Eye Units where these are currently not available and improving, facilities where these are inadequate.
3. Procurement and distribution of eye equipment and consumables.
4. Districts to include in their plans eye care programmes under their existing funding for health care provision.
5. Bringing on board eye care providers in private practice so as to maximise utilisation of the available human resource in the country.

**CONSOLIDATED SUMMARY OF SUBMISSIONS BY STAKE HOLDERS**

The following stakeholders submitted their views on the topic to your Committee:

- the Ministry of Health;
- Kitwe Central Hospital;
- Churches Health Association of Zambia (CHAZ);

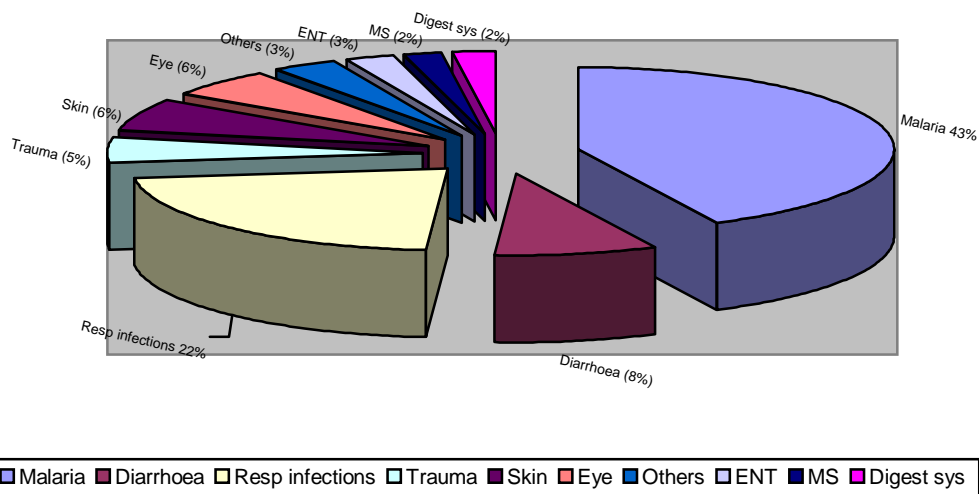
- World Health Organization (WHO);
- the International Association of the Lions Clubs District 413- Zambia; and
- the Zambia National Federation of the Blind.

Generally all the stakeholders expressed similar views and concerns on the topic. They were also cognisant of the fact that mortality directly due to eye conditions might not be as high but that these conditions affect productivity adversely. Eye conditions are also reported to be among the top ten causes of morbidity in the country. Further, although there is no scientific proof that blindness reduces life expectancy, the condition is such a debilitating situation to find oneself in.

The main concerns and observations of the stakeholders were that:

- (i) there is no specific Government Policy on the provision of eye health and care services; consequently the little efforts being made are uncoordinated resulting into provision of a poor service;
- (ii) eye health receives little advocacy and no high profiling is done;
- (iii) the high percentage of preventable blindness in the country is an indication that the country is not doing enough to adequately prevent and combat the diseases;
- (iv) eye health and care services are currently being provided at provincial centres, hence the rural community have no access to eye health and care services;
- (v) there is no training institution in the country offering a training programme for ophthalmic clinical officers and other eye health care workers;
- (vi) the country has inadequate specialized ophthalmic human resources at both national and provincial levels;
- (vii) lack of physical facilities, equipment and transport in the centres that have eye sections;
- (viii) the few available specialists concentrated in urban areas in a few health centres further disadvantage the rural population; and
- (ix) dependency on cooperating partners: The stakeholders felt that the country needs to stand on its own and continue with projects that are initiated by donors once they pull out.

### Top Ten Causes Of Morbidity, 2004



Source

*e of Data: Ministry of Health/Central Board of Health, HMIS*  
**ANALYSIS OF CURRENT STATUS OF OPHTHALMIC PERSONNEL IN THE COUNTRY**

#### Distribution of Selected Ophthalmic Personnel in the Country

Province	Ophthalmic Personnel						
	Ophthalmologists	Cataract Surgeon	Ophthalmic Clinical Officers/OM A	Optometrist	Refractionist	Low Vision Technician	Maintenance Technician
Eastern	1	1	4	0	0	0	1
Lusaka	8	1	5	5	0	0	0
Central	0	0	2	0	0	0	1
C/belt	4	0	10	1	0	0	0
Luapula	0	0	7	0	0	0	0
Northern	0	0	2	0	0	0	0
N/West	0	2	5	0	0	0	0
Western	0	0	5	0	0	0	0
Southern	0	0	3	0	0	0	0

Source: Vision 20/20 Update WHO Survey February 2006

#### Training of Ophthalmic Personnel needed in the country

Cadre	Total for country	Current training (of existing staff)		Future training (Next 5 Years)	
		In Country	Abroad	In Country	Abroad
Ophthalmologists	30	0	3	-	-
OCO/OMA	100	0	4	-	-
Cataract Surgeons	40	0	1	-	-
Optometrist	20	0	0	-	-
Refractionist	10	0	0	-	-
Low Vision (L.V.) Technicians	-	-	-	-	-

*Source: Vision 20/20 Update WHO Survey February 2006*

**Way Forward:**

The issues set out hereunder were highlighted for the way forward in trying to improve eye health care services.

- Government needs to recognize and support the existing eye care delivery system instead of being DONOR DEPENDANT, which is un-healthy for the nation. Once the donor pulls out, then the programme collapses. There is evidence of such situations.
- Infrastructure development: establishing eye units where they are currently un available and improving facilities where they are inadequate.
- Provision of appropriate equipment and supplies for eye health care.
- Formulation and finalisation of a specific policy on eye health care.
- Decentralization of technical plateau to district level hospitals. This will avoid a skewed distribution of staff in urban centres, as has been the case for most cadres in the health sector. Further there is need to build capacity in all districts of the country. This will also help in coordination of information to ensure that there are proper and reliable statistics.
- There is need to invest in training of more eye health care staff both locally and abroad. Currently, there is no local training for such a cadre in health. This entails putting in place such training institutions in the country by Government and cooperating partners.
- Recruitment or re-assigning a focal point person for non-communicable diseases (NCDs) in the Ministry of Health to push ahead implementation of activities (strategies and policies) including prevention of blindness.
- Political commitment to improvement of eye health care services.
- Contracting the services of private sector by the Government.
- There is need for a functional “Committee for the Prevention of Blindness”. with a national coordinator to represent all stakeholders in eye care services.

**COMMITTEE’S OBSERVATIONS AND RECOMMENDATIONS**

Your Committee are cognizant of the fact that Government has indicated that it will implement various interventions in the eye health care sector. However, your Committee wish to make the following observations:

- (i) the absence of a specific Government policy is a major drawback in the provision of eye health and care services;
- (ii) the country has up to the time of the study had no training programme and facilities, or a training institution for eye health workers; this has contributed to the shortage of skilled ophthalmic human resource in the country;
- (iii) health centres and hospitals that are offering eye care services generally lack ophthalmic human resource and have inadequate or no equipment at all;
- (iv) the current eye health services available are unevenly distributed; the rural areas have no access to eye health services since currently eye health services are concentrated at provincial levels and at major referral centres such as the University Teaching Hospital; this negates the Ministry of Health’s vision of providing Zambians with equity health care as close to the family as possible;
- (v) non-government stakeholders are willing to partner with Government; and
- (vi) the country does not have enough trained ophthalmic human resources.

Arising from the above observations, your Committee recommend as follows:

- (i) the Ministry of Health should urgently formulate and implement the policy on eye health care;
- (ii) the Government should expedite the planned training programme for eye health workers at Chainama college as well as the programme of training ophthalmologists outside the country;
- (iii) the Government should consider giving support to mission hospitals which have eye sections especially in terms of transport and improved funding, so that they help Government in outreach programmes;
- (iv) there is need to scale up provision of eye health care services to rural areas through the district centres so that the rural community can also be provided with the services; and
- (v) the Government should ensure that all health institutions and hospitals have a deliberate budgetary allocation for provision of eye health services.

## **PART II**

### **TOURS**

7. Your Committee undertook local tours to the University Teaching Hospital Eye Clinic and Seventh Day Adventist Lusaka Eye Hospital to familiarise themselves with the operations and challenges these institutions face in provision of eye care services. Your Committee also toured the Special Education Unit at Munali High School.

#### **Munali Boys High School**

Your Committee visited the school on 26<sup>th</sup> April, 2006 with the objective of touring the Special Education Unit for the visually impaired. However, while at the school, your Committee were informed that the Special Education Unit in fact catered for the visually and hearing impaired.

Your Committee further heard that both Munali Boys and Girls Schools were running the unit but that the administration part of the special education unit was being handled by the Munali Girls High School. The boys and girls learn from their respective high schools.

Your Committee were also informed that special education was being provided within the framework of the Government's Policy on pupils with special educational needs. In the policy, the strategy used is that of integrating pupils with special educational needs into mainstream institutions and provide them with necessary facilities.

Your Committee learnt that the two schools have remained committed to providing special education since its introduction at the school in 1974 but with a lot of challenges as set out below.

#### 1. *Accommodation*

The unit has a critical shortage of accommodation for the pupils. The number of beds is very minimal compared to the number of pupils. Out of the total student population of 202 pupils in boarding, there are only 101 dilapidated beds. This has resulted into some of the pupils sleeping in pairs per bed and others sleeping on the floor. The situation is unhealthy as it exposes the children to airborne diseases. Secondly, the boys hostel is not big enough. This has forced the pupils to start sleeping in the common room.

#### 2. *Pressure Cookers*

Out of the three pressure cookers that are in the kitchen only one is operational but unreliable.

3. *Classrooms*  
The Special Education department has a total of four classrooms, with one being used as a computer room. Out of the remaining three, two are in a dilapidated state, requiring urgent attention to the ceiling boards and the entire superstructure.
4. *Equipment for the blind and deaf pupils*  
Children with special needs require certain equipment to aid them in their learning. The school lacks the following equipment:
  - canes (walking sticks);
  - braille Printers ;
  - manual type writers;
  - perkins Bailers;
  - computers loaded with jaws software; and
  - audio metre.
5. *The policy on Children with Special Educational Needs*  
The policy is yet another problem because it requires the children or pupils with special educational needs to be integrated into mainstream institutions. However, teachers have difficulties in handling integrated classes because of the different needs of the normal and impaired children.
6. *Lack of skilled manpower both in sign language and specific subject areas such as Mathematics, Geography and Science.*
7. *Motivation*  
Teachers who are handling pupils with special needs have no special incentives.

#### **Committee's Observations:**

Your Committee make the following observations:

1. teachers have difficulties in handling integrated classes;
2. most of the teachers lack basic skills required to handle the deaf and the blind pupils;
3. the classes are over enrolled, making it difficult to deal with an integrated class of over 50 pupils;
4. the children with special needs are not even assessed during enrolment to determine the level of disability; this leads to children with severe disabilities being put in the same classes with normal children;
5. children with special needs are denied the chance to learn important subjects such as Mathematics and Science making it difficult for them to go to the institutions of higher learning such as universities; and
6. teachers teaching classes of children with special needs are not motivated and hence have low morale and passion for the job.

#### **Committee's Recommendations:**

Your Committee make the following recommendations:

1. the Government should source funding to enable the school construct a new hostel to alleviate the problem of accommodation;
2. the Government should consider acquiring new pressure cookers for the kitchen;
3. the Government should mobilize adequate resources for the school so that it could rehabilitate the dilapidated class rooms as they pose a danger to the pupils and the teachers;
4. the Government should find necessary resources to enable the school procure the equipment the school needs to give quality education to the pupils with special needs;
5. the Government should revisit the policy and specifically, the integration strategy so that it can work in favour of the pupils with special needs, for whom it was formulated;
6. the Government should recruit and retrain the teaching staff to equip them with skills that will enable them teach Mathematics and Science to the blind and the deaf; and
7. the Government should consider introducing an allowance for teachers who are teaching pupils with special needs in order to motivate them.

### **University Teaching Hospital Eye Clinic**

Your Committee note with happiness the positive development taking place at University Teaching Hospital. The Government, in partnership with donors, is in the process of constructing an Eye Centre of Excellence within the UTH premises. Although there are outstanding issues of approval of plans and the tender procedures as well as Government funding, your Committee commend Government for realising that there is need for provision of quality eye care services to its citizens and starting the eye hospital project.

#### **Committee's Observations:**

Your Committee make the following observations:

1. the eye clinic lacks equipment like microscopes;
2. the eye clinic lacks trained human resource;
3. bed space is limited for both male and female eye wards; and
4. the current location of the eye clinic is not conducive to eye patients. However, your Committee welcome the proposed new site for construction of the Eye Centre of Excellence.

#### **Committee's Recommendations:**

Your Committee make the following recommendations:

- 1 the Government should source funds to enable the hospital procure equipment for the eye clinic;
- 2 the Government should urgently begin training eye health workers locally in order to end the shortage of human resources at the clinic and cut costs of sending staff outside the country for training; and
- 3 the Government should urgently expedite the tender procedures and fulfil its part by releasing the counterpart funding towards the project as the cooperating partners have honoured their part.

### **Seventh Day Adventist Lusaka Eye Hospital**

Your Committee make the following observations:

- 1 the hospital is offering eye care services to all sections of the community;
- 2 in its quest to serve the community, the hospital has also started a dental clinic;
- 3 the hospital is well equipped with necessary equipment required in the provision of eye health services;
- 4 the hospital is ready to compliment Government efforts in training eye health workers;

- 5 the hospital is too dependant on foreign volunteers and may be threatened with operational problems if the volunteers leave;
- 6 the hospital lacks adequate human and financial resources as it is run on church offerings and tithes; and
- 7 the majority of the public do not seem to know about the existence of the hospital and the services it offers.

**Committee's Recommendations:**

Your Committee make the following recommendations:

1. the Government should seriously consider turning the hospital into a grant-aided institution in appreciation of the services it is offering to the community and the nation;
2. the Government should consider seconding some Government health workers to the hospital to improve on the staffing; and
3. the Government should consider helping the hospital make known to the public the eye and dental care services it is providing.

**PART III**

**CONSIDERATION OF OUTSTANDING ISSUES ON THE COMMITTEE'S REPORT FOR 2005**

**The Mandate and Operations of the Department of Social Welfare vis-à-vis the Welfare of Children**

8. Your previous Committee had recommended that:
  - (i) in addition to Government Gazette Notice No. 547 of 21<sup>st</sup> September 2004, which clarified the roles of the Departments of Social Welfare and Child Affairs, the Government should consider placing the two departments under one ministry in order to streamline their operations;
  - (ii) the Government should ensure that the capacity in the Department of Social Welfare was built through the recruitment of adequate staff at district level and by the provision of transport and funds to implement projects for the children; and
  - (iii) the Government should ensure that the National Social Welfare Policy that had been in draft form for many years was finalised and implemented.

In response it was reported in the Action-Taken Report that Government acknowledged with approval the recommendation that would see the two departments of Social Welfare and Child Affairs in one ministry in order to streamline their operations. Child issues or child affairs which the Department of Child Affairs was mandated to oversee within the statutory framework for example, child adoption, foster care, children's homes, Juvenile Courts etc, which fell under the department for Social Welfare. To separate them in different departments under two different ministries had made operations difficult. The Department of Social Welfare would, therefore, not object to having the two departments under one ministry as that would assist in maximizing the use of the meagre resources.

It was also reported that the Ministry of Community Development and Social Services had been granted Treasury Authority for re-structuring. The Ministry had already internally advertised for the new positions and would soon advertise externally to beef-up staff within the new structure. It was hoped that the exercise would be completed by June 2006. Consequently, by end of 2006, the capacity of the Department of Social Welfare should be strengthened.



It was further reported that the National Social Welfare Policy had been finalised and had taken into account Gazette Notice No. 547 of 21<sup>st</sup> September, 2004. The Policy was in the process of being submitted to Cabinet for approval.

#### **Committee's Observations and Recommendations**

Your Committee make the following observations:

- (i) the responses from Government have not given the time frame, when the two departments will be placed under one ministry and which ministry it will be;
- (ii) it is not clear as to when exactly the National Social Welfare Policy will be submitted before Cabinet for approval; and
- (iii) there are no figures of the number of staff the Department of Social Welfare currently has and the expected number of staff after the restructuring exercise.

Your Committee, therefore, request a progress report from the Ministry of Community Development and Social Services on the above issues.

#### **The Role of Traditional Medicine in the Management of HIV and AIDS in Zambia**

Arising from the submissions of various stakeholders, your previous Committee had made the following observations:

- (i) there was no Government policy to guide the application of traditional remedies, resulting in chaos in its administration;
- (ii) there was inadequate legal framework within which to regulate the application of traditional medicines; specifically, there was no regulatory body responsible for regulating the conduct of traditional healers;
- (iii) due to inadequate funding to research institutions such as the National Institute for Scientific and Industrial Research (NISIR) and Tropical Diseases Research Centre (TDRC), research to verify the potency and efficacy of traditional remedies was taking too long, thereby discouraging traditional healers from submitting drugs for testing;
- (iv) very little had been done to integrate the practice of traditional medicine with conventional medicine, resulting in the practitioners from the two fields viewing each other with suspicion;
- (v) many plants with medicinal value were threatened with extinction due to continued indiscriminate harvesting, without replacement, by the traditional healers; and
- (vi) the lack of a patenting mechanism for traditional medicines was promoting secrecy among traditional healers, which in turn was frustrating efforts to integrate traditional medicine with conventional medicine.

In view of the foregoing, your previous Committee had made the following recommendations:

- (i) the Government should urgently develop a comprehensive and clear policy on traditional medicine;
- (ii) the Government should assist to establish a strong regulatory body to provide standards for the operations of traditional healers;
- (iii) the Government should develop measures to reduce the gap between traditional healers and conventional doctors, through general sensitisation and training programmes;

- (iv) the Government should increase its funding to research centres such as the Tropical Diseases Research Centre and the National Institute for Scientific and Industrial Research so that claims from traditional healers to cure HIV/AIDS were certified promptly;
- (v) the Government, in close collaboration with stakeholders, should develop a patenting mechanism so that traditional healers whose herbs proved to be effective could patent their drugs; and
- (vi) the Government should mobilize funding to enable the Traditional Healers Practitioners Association of Zambia and its membership to grow herbal gardens on the land that had already been allocated to them in order to prevent deforestation and extinction of important herbs.

It was reported in the Action Taken Report that according to the National HIV/AIDS Policy the following statement had been made with regard to the utilisation of alternative/traditional remedies:

*Objective:* To promote the use of safe alternative or traditional remedies.

*Measures:* Traditional medicine had always been part of Zambia's traditional medical practice. However, so far no serious scientific inquiry had been undertaken with a view to establishing its efficacy, safety and potency. In order to address this problem, the Government shall:

- (i) facilitate co-operation and collaboration between and among formal and alternative health practitioners with a view to ascertaining positive traditional medical practices that might help in combating the HIV/AIDS pandemic;
- (ii) promote public awareness of known benefits and limitations of different types of alternative remedies so as to enable people make informed choices;
- (iii) promote scientific integration and verification of traditional medicine and claims of successful treatment of HIV/AIDS, STIs and TB; and
- (iv) facilitate enacting laws and developing regulations, which shall support and promote rational and safe use of traditional/alternative remedies to all levels of health care delivery systems.

Further, the Government of Zambia had established the National AIDS Council (NAC) to co-ordinate, monitor and evaluate all HIV/AIDS activities with the aim of reducing HIV transmission and the suffering of those infected and affected. Among the prescribed functions in the Act section 4, NAC was empowered to form committees. Therefore, NAC had formed a Traditional/Alternative Remedies Technical Working Group to address the issues of alternative/traditional remedies. In addition, an Institutional Biosafety Committee (IBC) had been formed.

#### **Institutional Biosafety Committee (IBC)**

The IBC would function as a clearing house on traditional/alternative remedies research activities. Specifically some of the functions of the IBC would be:

1. to assess the safety and efficacy of traditional/alternative remedies; and
2. to identify potential hazards and risks to health and environment.

Other functions of the IBC would be to:

- (i) review and certify traditional/alternative remedies;
- (ii) see whether the Code of Ethics is adhered to;
- (iii) provide local institutional oversight of research with traditional/alternative remedies; and
- (iv) request safety reports from the investigators/researchers.

To reduce the gap between traditional healers and conventional doctors, it was reported that the Traditional Health Practitioners Association of Zambia (THPAZ) were appointed as a lead agency by the Zambia National Aids Network under the Global Fund and had, among other things, held skills training and strategic planning workshops for their members in the years 2004 and 2005. In addition THAPAZ members participated in trainings organised by district health management teams and other organisations.

During the year 2004/5, THPAZ endeavoured to recruit a monitoring and evaluation officer and a training officer to add to their secretariat. Apart from the National Executive Committee, the THPAZ had other sub-committees such as research, disciplinary, museum, information and publicity, advisory, funerals and others. THPAZ had also been active in natural remedies research.

Many HIV/AIDS patients in Zambia take traditional medicines even though these medicines have not been scientifically validated to have anti-HIV activity. The National Institute for Scientific and Industrial Research (NISIR), the University Teaching Hospital Virology laboratory (UTH-VL) and the University of Zambia (UNZA) were identified to have the capacity of screening and validating traditional medicines. The UTH-VL has the capacity to carry out in-vitro analysis for anti-HIV activity while NISIR and UNZA have the capacity to isolate and identify the compounds in a given traditional medicine concoction. Traditional Health Practitioners Association of Zambia (THPAZ) provided the traditional medicines from its members through the National AIDS Council (NAC) who in turn handed it to the research institutions.

Eighteen herbal formulations prepared by the traditional healers were analysed for anti-HIV 1 activity. The experiments however, needed to be repeated under certain conditions in order to make valid conclusions.

A research proposal “an observational clinical study on safety and efficacy of five traditional herbal medicines namely: Mailacine, Mayeyanin, Sondashi, Ngoma and Universal formulations in Lusaka, Zambia” had began. The Government had made available \$56,000 to support the above mentioned research proposal. So far there were 25 patients undergoing the observational clinical study.

It was further reported that although patent mechanisms have not yet been established, the following efforts have been made towards the promotion of scientific interrogation and verification of traditional medicine and claims of successful treatment of HIV/AIDS, STIs and TB:

- (i) the guidelines for clinical observational study of traditional herbal medicine in WHO African Region have been adopted;
- (ii) a Code of Ethics and conduct for traditional and alternative medicine practitioners has been developed;
- (iii) a way of receiving herbal alternative remedies samples for Laboratory testing has been established; and
- (iv) a Memorandum of Understanding on validating the efficacy and safety of traditional medicines/herbs and alternative remedies to further their scientific development and packaging for management of HIV/AIDS/STIs/TB in Zambia between National AIDS Council and Traditional Health Association and/or Individual Traditional Health Practitioner/Alternative Remedy Provider has been developed.

It was also reported that Government appreciated your previous Committee’s concerns and stated that plans were underway to implement the growing of herbal gardens project.

#### **Committee’s Observations and Recommendations**

Your Committee request the Ministry of Health to furnish them with a progress report on what has been done so far on the reported measures to promote the use of safe alternative or traditional remedies and the plans to implement the growing of herbal gardens project.

### **Quality Assurance in the University of Zambia's School of Medicine**

Your previous Committee had recommended as follows:

- (i) the Government and the University of Zambia Senate should urgently approve the School's roadmap and provide support to ensure the successful implementation of the School's recommendations;
- (ii) the Government should provide adequate funding to the School in order to ensure that the limited infrastructure at the School was expanded in line with the new academic programmes; and
- (iii) the Government should ensure the retention of qualified manpower at the school through the improvement of conditions of service.

In response to this, through the Action Taken Report, it was reported that the issue of quality assurance in the School of Medicine of the University of Zambia was presented to the 33<sup>rd</sup> Meeting of Senate held on 9<sup>th</sup> November, 2005. Senate was generally in agreement with the content of the document: Policy, Governance and Administration, Curriculum Goals (MBChB) Handbook 2005 presented by the School of Medicine. Senate decided, however, that an Adhoc Committee should be constituted to systematically and critically study the roadmap in the context of the operations of the School of Medicine. The Committee would then report to Senate at its 34<sup>th</sup> Meeting scheduled to take place in March, 2006. It was after Senate had adopted the report of the Adhoc Committee that it would be in a position to report to the Ministry of Health and indeed to other stakeholders.

As regards funding for expansion of infrastructure, it was reported that the University was desirous of expanding the infrastructure both at Ridgeway and at the Great East Road Campuses. The Central Administration had developed a roadmap for the development of the estate of the Great East Road Campus but was yet to develop one for the Ridgeway Campus. The anticipated mode of such developments was the Public – Private Partnership.

It was also reported that conditions of service in the University were generally determined by the level of resources provided to the University through the monthly grant and the results of the negotiations with the academic staff union. It was the desire of the University Central Administration to improve the conditions of service to a level at which they would be comparable with those in other Universities in the region. It was therefore, expected that Government would facilitate the process of improving the conditions of service.

### **Committee's Observations and Recommendations**

Your Committee request for a progress report from the Ministry of Health on the process of approving the University's road map. Your Committee also urge the relevant Ministry to implement their recommendations to expand infrastructure and retain qualified manpower at the University.

### **Progress in the Attainment of Health-related Millennium Development Goals (MDGs)**

Your previous Committee had among, other things, recommended the following:

- (i) the Government should ensure accessibility to ART to all Zambians who need it through strengthening laboratories and staff capacities all over the country and ensuring that other costs related to ART are kept low;
- (ii) the Government should step up measures to reduce the child mortality rate by ensuring that all health centres have adequate trained health workers and adequate information, education and communication materials;

- (iii) the Government should embark on accelerated measures in order to reduce maternal mortality in Zambia, specifically the Government should strengthen the district level in terms of transport and communications and human resource retention; and
- (iv) the Government should ensure that the various interventions that had hitherto not been done on a large scale were rapidly scaled up to all parts of the country.

The following was reported in the Action -Taken Report:

**Anti-retroviral Treatment (ART)**

- (i) the Zambian ART programme is on track and continued to do well. In spite of not meeting the "100,000 patients on ARVs by end of 2005" this ambitious target has spurred the Government to work extra hard. The current levels stand at more than 40,000 on treatment;
- (ii) another very significant event has been the announcement that ART and its support laboratory investigations would be free in public institutions. This has given impetus, which the expansion phase would continue to build on;
- (iii) the focus in ART is on effective use of combination ARVs to slow progression of disease, improve quality of life and reduce transmission rates from infected to non-infected, including from mother to child;
- (iv) the component has been strengthened to provide effective treatment of opportunistic infections including TB, with which a collaborative body has been formed in the past year;
- (v) ART programme has been linked with PMTCT programme, to give expanded care for pregnant women who are HIV positive, so that assessment, treatment and support could be given to their partners as well as the children; this has been piloted and is planned for scale up;
- (vi) communities and families are encouraged to take part in care; this forms part of the communications strategy and is aiming at reducing stigma and discrimination; it is articulated in the finalized AIDS policy; and
- (vii) the Ministry of Health has continued to collaborate with faith based organisations in continued home based care.

Regarding the measures to reduce the child mortality rate, the following strategies were being implemented:

**The Expanded Programme on Immunization (EPI)** - Immunization coverage had improved with some districts reaching 80 percent coverage, which is the desired minimum target for the whole country. This was being achieved by utilizing Routine and Campaign immunization against the common childhood illnesses. The past year also saw the launching of hepatitis immunization, which has added to the number of target illnesses.

**Biannual Child Health Week** offers an expanded package, including immunization for children missed during routine immunizations, micronutrient supplementation, deworming, supply and re-treatment in Insecticide Treated bed nets and is being used for a more holistic approach to care for the whole family. Mothers are able to access family planning, as well as Tetanus Toxoid Immunization.

**IMCI - MOR** has continued to expand access to care of the child as a whole and not just the suspected illness by training more health workers in this strategy. The integrated management of childhood illnesses was a proven strategy in child survival and MOH aimed for more staff to be trained to achieve access for every ill child.

**REDS** - reaching every district strategy (REDS) for comprehensive care for the ill and well child involved the Ministry of Health's deliberate policy to have equity of access in the whole country to the child survival interventions being applied. This strategy is on course and available resources both locally and through partnerships are being deliberately channelled to this activity.

**Focus on the newborn** - The highest morbidity and mortality rates were seen in the first seven days of life, and Ministry of Health had developed a strategy to mitigate the common causes of the morbidity. The lessons learnt would be utilized for wider application, and so far midwives were being trained in this strategy. It was further reported that specific actions taken in the past year to reduce maternal mortality rate included the following:

- (i) infrastructure development – construction of maternity delivery wings (annexes) in health centres, with the aim to reduce number of home deliveries;
- (ii) referral systems - radio systems had been set up in the districts for ease of communication between the primary health centres and the referral centre; delays in accessing care were often a major contributor to maternal death;
- (iii) doctors deployment – eighty doctors had been deployed to rural areas, to increase access to skilled attendants; and
- (iv) infection prevention and control-Sepsis and unsafe abortions remain major causes of women's illness and death.

The Ministry of Health with its cooperating partners had undertaken training of health workers countrywide in injection safety as well as Post Abortion Care. A national PAC Co-ordinator had been employed. Other measures focused on the newborn are set out below.

- (i) Emergency Obstetric Care (EOC), which is care given to pregnant women with complications is key in mitigating maternal mortality and morbidity. The MOH had undertaken an extensive survey to assess the country's needs and identify specific gaps. The report had given the needs assessment, with recommendations, and some of the proven interventions were being implemented, for example, active management of labour.
- (ii) Strengthening Antenatal Care (ANC) Services. Through PMTCT training, ANC services were currently being adapted to provide Focused Antenatal Care, with emphasis on quality of service during a visit, and not just the quantity (number) of visits.

It was also reported in the Action-Taken Report on the scaling up of various interventions and strategies that had been employed to achieve the MDGs as set out below.

1. **TB/HIV AIDS DOTS expansion and strengthening**

Government was implementing the Directly Observed Treatment Short courses (DOTS) strategy in all the districts in the country and was expanding it involving full participation of the communities, community leaders, traditional healers and the private sector. Capacity building had been done in health workers and communities to strengthen the DOTS strategy. TB treatment has been standardised and there is in place a standardised reporting and recording system as well as a monitoring and evaluation system. There are a number of community TB treatment supporters in almost all districts but there was need to continue training them in case finding as well as in contact tracing, diagnostic facilities also need to be strengthened. There is also an established working relationship with a number of local and international co-operating partners in TB control.

2. **TB/HIV Collaborative Activities**

HIV has complicated TB control and therefore the importance of addressing TB/HIV co-infection

can not be over emphasized. The TB programme has thus initiated the formation of a TB/HIV coordinating body to facilitate the TB/HIV collaborative activities. Seventy percent of the TB patients are co-infected with HIV, and TB is the commonest opportunistic infection in people living with HIV and AIDS. Patients with TB, therefore, are offered Diagnostic Counselling and Testing and referred to appropriate care depending on the results of the tests and of course TB treatment is instituted. Patients with HIV infection are screened for TB and put on TB preventive therapy if eligible and if they are found to have TB then treatment is instituted.

3. **Community Participation**

In order to achieve good cure rates and to improve on case detection, it is important to involve the communities as much as possible. The TB programme is therefore working closely with a number of Community Based Organisations and as well as community health workers. The programme is also working in collaboration with other ministries such as the Zambia Defence Force Medical Services; non-medical military personnel have been trained in TB control and as treatment supporters.

4. **Drug Supplies**

The TB programme has made sure that there is an assured Drug Supply for the treatment of TB patients without interruption. Global Drug Facility gave Zambia a grant in terms of the drugs supplies which would, however, be expiring in 2007. In order to improve on adherence to treatment by the patient and to reduce the number of patients defaulting from treatment the programme planned to introduce the use of the 4 Fixed Dose Combinations (4FDCs). The 4FDCs had been piloted in Central Province with the intent to roll out to other provinces.

5. **Advocacy, Communication and Social Mobilisation**

The TB programme embarked on a strategy to sensitise and educate communities and the general public in TB control and prevention as well as behavioural change in terms of health living. ITC materials had been developed and distributed.

***Malaria***

A lot of efforts have been carried out in malaria control to reduce maternal and child mortality, a part of the attainment of the MDGs. The areas of malaria control are Indoor Residual Spraying (IRS), Insecticide Treated Nets (ITNs), Case Management and Intermittent Presumptive Treatment (IPT).

***Insecticide Treated Nets***

The Government was scaling up ITN ownership from 50 percent. It was noted that most nets were owned by higher income households. Government had introduced mass distribution of free nets to ensure equal ownership between all social sectors. Luangwa and Kalomo were in 2005 given nets as pilot districts. All eligible districts should be covered in 2006.

***Indoor Residual Spraying***

In 2005 Government sprayed 8 districts. In 2006, the number of districts being sprayed had increased to 15.

***IPT and Case Management***

Government was training more community health workers, microscopists and had procured rapid diagnostic tests to ensure that patients received the recommended health care within 24 hours of onset of symptoms.

A new concept focused on antenatal care had been adopted to increase uptake of Intermittent Presumptive Treatment.

**Malaria Epidemics**

The Government had prepared and distributed technical knowledge on how to control malaria epidemics.

This had enabled health workers become equipped on how to control epidemics.

### **Committee's Observations and Recommendations**

Your Committee note the submission and urge the Ministry of Health to:

- ensure that partners of pregnant mothers who undergo mandatory testing in order to prevent mother to child transmission also undergo voluntary counselling and testing;
- ensure that ART is free in public institutions as has been announced;
- build capacity in all health centres by increasing the number of trained health workers, and provide transport and communication equipment which is user friendly; and
- review the Indoor Residual Spraying programme to ascertain its effectiveness.

### **COMMITTEE TOURS**

Your previous Committee had undertaken local tours in order to familiarize themselves with the operations of health and social welfare institutions.

### **University of Zambia 's School of Medicine**

Your previous Committee had recommended that:

- (i) the Government should ensure that lecturers who also perform call duties at the University Teaching Hospital were paid a special allowance in order to motivate them to perform their duties;
- (ii) the Government should take urgent measures to ensure that the entire Ridgeway Campus, which was under the Ministry of Education, was dedicated to the School rather than the current situation where some infrastructure was being rented out to private businesses. These included tuition classrooms, saloons, bars and other facilities; and
- (iii) the Government should mobilize adequate resources for the School so that it could rehabilitate the dilapidated infrastructure and replace the obsolete equipment in the laboratories.

It was reported in the Action-Taken Report that the University remunerated lecturers in the School of Medicine in accordance with the ruling terms and conditions of service under which staff were engaged in the University. However, it was acknowledged that apart from the usual teaching responsibilities, the members of staff also provided services to the University Teaching Hospital in clinical functions. In this regard, it would be appropriate that these members of staff be remunerated for the services that they provided to the University Teaching Hospital. The University currently did not have the ability to meet such additional payments since all remunerations to University staff were the responsibility of Government through the monthly subvention. It would be expected that if approved, such payments must be catered for in the subvention.

The University Central Administration was in the process of ensuring that the space available at the Ridgeway Campus was used entirely for activities conducted by the University of Zambia. In this regard, discussions were underway to ensure that as much of the space as possible was dedicated to the School of Medicine. However, some of the space may continue to be utilized by the School of Education due to historical reasons. It was expected that this matter would be resolved within the year 2006.

With regard to rehabilitation, it was reported that funds had been made available to the University of Zambia for rehabilitation of infrastructure in 2003 and 2004. No funds were made available for that activity in 2005 and discussions on the 2006 budget had indicated that there was no provision for that activity in 2006. Nevertheless, the University Central Administration had sought authority from the Ministry of Education to utilize part of the sector pool fund allocation to the University, to rehabilitate dilapidated infrastructure and to replace obsolete equipment in the laboratories.

To that end, it was planned that that activity would cover both the Ridgeway and the Great East Road Campuses of the University. The level of rehabilitation achieved would be dictated by the level of resources made available for this purpose. The Central Administration of the University expected that



adequate resources would be allocated by the Ministry of Education.

#### **Committee's Observations and Recommendations**

Arising from the above, your Committee make the following recommendations:

- (i) the Ministry of Health should urgently find means and ways of remunerating the lecturers in the School of Medicine for the services that they provide to the University Teaching Hospital;
- (ii) ninety percent of space available at Ridgeway Campus be given to the School of Medicine; and
- (iii) the Ministry of Education should allocate adequate funding to the School to ensure that laboratories and infrastructure are rehabilitated.

#### **DISTRICT SOCIAL WELFARE OFFICES**

Your previous Committee had visited Social Welfare Offices in Kabwe, Kapiri Mposhi, Ndola and Livingstone districts and had observed that they were facing the following challenges:

- (a) lack of transport to reach out to the remote parts of the districts;
- (b) inadequate staff at district level, thereby overburdening the officers on the ground;
- (c) erratic funding for programmes and recurrent expenditures; and
- (d) erratic release of funds by the Ministry of Finance and National Planning, particularly for Public Welfare Assistance Scheme (PWAS) activities often with little predictability or communication concerning the timing and level of each release.

In view of the foregoing, your Committee urged the Government to increase its budgetary allocation to the Ministry of Community Development and Social Welfare, so that it could implement social welfare services in an effective manner. Further, the Government should mobilize transport for the department at district level.

In response it was reported in the Action-Taken Report that the Government had increased its budgetary allocation in 2006 in order to enable it implement social welfare services effectively and also purchase the relevant resources needed urgently.

#### **Committee's Observations and Recommendations**

Your Committee urge the Ministry of Community Development and Social Services to ensure that the increased budgetary allocation is used appropriately to address the issues raised by your previous Committee. Your Committee would like to have a progress report on the matter.

#### **HOSPITALS**

##### **Kapiri Mposhi Hospital**

Your previous Committee had made the following recommendations:

- (i) the Government should urgently intervene in order to resolve the problem that the local management were facing with the contractor and ensure that the hospital project was completed without delay;
- (ii) in order to save lives, the Government should source money to enable the hospital procure key equipment such as incubators and resuscitators; and
- (iii) the Government should work out measures to promote exchange visits among hospital staff so as to enable them to learn from model projects such as the Kapiri Mposhi VCT programme.

It was reported in the Action-Taken Report that it was true that construction of the new hospital had been slow despite the contractor having been paid K600 million but the payment was not made three years ago but in 2005. Following intervention by the Ministry of Health after the site meeting held in November, 2005, some progress was noticed in the construction of the hospital. The main building reached roof level

and a quarter of the roofing had been done by the 5th of December, 2005. The drainage system was partially done while window frames were fixed and external wall plastering done. The maternity wing was at ring beam level while moulding of blocks for the maternity wing continued.

Work had recently slowed down due to the mandatory industrial break during the Christmas and New Year Holidays. Efforts were being made to ensure that the contractor performed according to the contract signed with the Government. Purchase of the resuscitator was in place. As part of the hospital project Government would source funds for procurement of all the required medical equipment including incubators.

Districts and hospitals were being encouraged to put in their annual action plans, exchange visits to centres of excellence like the Kapiri Mposhi V.C.T. programme. It was hoped that the districts and other health institutions would take advantage of this provision and make funds available to visit and learn from the Kapiri Mposhi V.C.T. programme experience.

### **Committee's Observations and Recommendations**

Your Committee request further details on what the Ministry of Health is doing to ensure that the contractor does not deliberately delay the project further. They also recommend that in future, contracts entered into with contractors should be in such a way that contractors who deliberately delay projects are penalised.

### **Choma District Hospital**

In relation to Choma District Hospital, your previous Committee had recommended that:

- (i) the Government should source funds to enable the district construct a new hospital and staff houses in order to meet the demand for health services and avert many operational problems;
- (ii) as an urgent measure, the Government should provide funds to the hospital so that it could improve the sewer system and connect electricity to the forty seven housing units, which the hospital had, but were being shunned by staff; and
- (iii) the Government should ensure that the hospital was provided with transport in order to ease their operational problems.

It was reported in the Action-Taken Report that it was Government Policy to construct hospitals in districts where they did not exist. In this connection, the Government was already constructing hospitals in Shangombo, Isoka and Kapiri Mposhi districts. Other districts lined up for construction of hospitals included Chadiza, Mumbwa and Samfya. Choma District Hospital would, therefore, be constructed as funds became available.

K100m had been allocated to Choma Hospital from 2005 financial year PRP funding received at the Provincial Administration for rehabilitation of the hospital. The funds were yet to be released by Provincial Administration to Choma Hospital. Quotations including ZESCO quotation amounting to K24m were sent last year to Provincial Administration. Due to lack of a new vehicle the Provincial Health Office in Livingstone released a relief vehicle to Choma Hospital in May, 2005. This was an old vehicle, a Suzuki Grand Vitara which was meant for administrative duties. Government was making efforts to source funds to procure vehicles for hospitals and Choma Hospital would be considered when the vehicles were available.

### **Committee's Observations and Recommendations**

Your Committee observe that the amount of money allocated to the hospital from the 2005 financial year PRP is not enough and therefore, urge the Ministry of Health to source more funds to enable the hospital rehabilitate the infrastructure.

## **Conclusion**

9. In conclusion, your Committee wish to express their gratitude to you Mr Speaker and the office of the Clerk of the National Assembly for the support rendered to them during the year. They are also indebted to all witnesses who appeared before them, for their co-operation in providing the necessary memoranda and briefs. Your Committee are hopeful that the observations and recommendations contained in this report will go a long way in improving the Health and Community Development and Social Services sectors in Zambia.

May 2006  
**LUSAKA**

Y D Mukanga, MP  
**CHAIRPERSON**

/cm